

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5801

## CERTIFICATE OF DEATH

05791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 Hunt Club Road</b>				d. STREET ADDRESS <b>7 Hunt Club Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MINNA</b> Middle <b>AMBERMAN</b> Last <b>AMBERMAN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1879</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Nansge</b>				14. MOTHER'S MAIDEN NAME <b>Emilie Brandt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Adelbert Amberman-7 Hunt Club Road-Elkridge</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> <b>420.1</b> DUE TO <b>chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterial hypertension</b> (c) <b>bronchiectasis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>6 mo</b> <b>7 yrs</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Jan 1955</b> to <b>May 12, 1958</b> , that I last saw the deceased alive on <b>May 12, 1958</b> , and that death occurred at <b>10:30</b> M, from the causes and on the date stated above.							DATE SIGNED <b>5/13/58</b>
ACTUAL SIGNATURE <b>B B Brumbaugh</b>		M.D. <b>3609 Main St</b>		ADDRESS (Street, city or town, state) <b>Elkridge 27 Md</b>			
PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/15/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker &amp; Sons</b>				ADDRESS <b>Balto 17, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 16 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES E. HARRIS		Male		45		1873		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
Carpenter		Typhoid Fever		Natural		10 days		1918		BALTIMORE		BALTIMORE		MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
1918		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND		BALTIMORE		BALTIMORE		MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
1918		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND		BALTIMORE		BALTIMORE		MARYLAND	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE CLERK OF THE COURT OF COMMONS, BALTIMORE, MARYLAND.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG229 6-5-58 et

05792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>			c. LENGTH OF STAY IN 1b <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 40 W. St. Johns Lane</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WILLIE LEE ASH</b>			4. DATE OF DEATH <b>5-25-58</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Colored</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>May 15, 1915</b>		
9. AGE (in years last birthday) <b>43</b> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Mason Ash</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Evans</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>John Ash</b>			Address <b>802 S. Fremont Ave.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral Pulmonary Tuberculosis with Cavitations</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Donald E Fisher</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <b>5-25-58</b>					
EXAMINER'S NAME (Type) <b>Donald E. Fisher M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 1</b>					
22b. DATE THEREOF <b>5/29/58</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National 1</b>					
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Rice</b>					
ADDRESS <b>661 W. Barre St.</b>					
24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>					
24b. REGISTRAR'S SIGNATURE <b>W. S. Leach</b>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO COffin

DATE OF ENTRY INTO GRAVE

DATE OF ENTRY INTO BURIAL

DATE OF ENTRY INTO INTERMENT

DATE OF ENTRY INTO CREMATION

DATE OF ENTRY INTO DISPOSITION

DATE OF ENTRY INTO FINAL REST

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5813

## CERTIFICATE OF DEATH

### 05793

Reg. Dist. No. 195

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased resided. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		c. LENGTH OF STAY IN 1b <u>94 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>Balto. Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Busey</u> Last <u>Busey</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26/1864</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Savage, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Busey</u>		14. MOTHER'S MAIDEN NAME <u>Matthia Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u> Dorothy Mayhugh Savage, Md</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>11 mos.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>May 24<sup>th</sup></u> 19 <u>58</u> , to <u>May 25<sup>th</sup></u> 19 <u>58</u> , that I last saw the deceased alive on <u>May 25<sup>th</sup></u> 19 <u>58</u> , and that death occurred at <u>3a</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Mark E. Shipley</u>		ADDRESS (Street, city or town, state) <u>Savage, Md</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>		DATE SIGNED <u>5/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 27, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Savage Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Caraldan</u>		ADDRESS <u>Ransel Md</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>JUN 2 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH OF \_\_\_\_\_

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of undertaker		12. Signature of funeral home	
13. Signature of family		14. Signature of witnesses		15. Signature of coroner	
16. Signature of jury		17. Signature of jury		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DEATH OF \_\_\_\_\_

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DEATH OF \_\_\_\_\_

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DEATH OF \_\_\_\_\_

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DEATH OF \_\_\_\_\_

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DEATH OF \_\_\_\_\_

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DEATH OF \_\_\_\_\_

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

## 5804 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD</b> First <b>FRANCIS</b> Middle <b>CAVEY</b> Last		4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Noah Cavey</b>		14. MOTHER'S MAIDEN NAME <b>Emma Stigler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Edward F. Cavey</b>		Address <b>Woodstock, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension, Cerebral Sclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>14 56 to 25 May 58</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1950</b> to <b>19 May 1958</b> , that I last saw the deceased alive on <b>25 May 1958</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard E. Hall</b> M.D.		ADDRESS (Street, city or town, state) <b>Sykesville, Md.</b> DATE SIGNED <b>25 May 58</b>	
PHYSICIAN'S NAME (Type) <b>Howard E. Hall M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/28/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>	22d. LOCATION (City, town, or county) (State) <b>Alpha Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. HIGINBOTHOM</b>		ADDRESS <b>Ellicott City, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**5805 CERTIFICATE OF DEATH**

05795/95  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Mae</u> Last <u>Chance</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 16 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Nat'l Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Clay Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>Ella Lydia Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>123-45-6789</u>	
17. INFORMANT Address <u>Mrs Sarah J. Wallace Tall Church</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> 422.1 DUE TO (b) <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1st 1958</u> to <u>May 16th 1958</u> , that I last saw the deceased alive on <u>May 16th 1958</u> , and that death occurred at <u>12 noon</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Frank E Shipley, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Canavan, Laurel, Md</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 21 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>DeWitt Canavan</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED: <i>John Doe</i></p>		<p>2. SEX: <i>Male</i></p>	
<p>3. AGE: <i>45</i></p>		<p>4. DATE OF BIRTH: <i>Jan 15 1900</i></p>	
<p>5. PLACE OF BIRTH: <i>New York City</i></p>		<p>6. OCCUPATION: <i>Teacher</i></p>	
<p>7. CAUSE OF DEATH: <i>Heart Disease</i></p>		<p>8. DATE OF DEATH: <i>Dec 10 1945</i></p>	
<p>9. PLACE OF DEATH: <i>Home</i></p>		<p>10. SIGNATURE OF PHYSICIAN: <i>[Signature]</i></p>	
<p>11. SIGNATURE OF REGISTRAR: <i>[Signature]</i></p>		<p>12. OFFICIAL SEAL: <i>[Seal]</i></p>	

5806 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor 16 X-2</u>				d. STREET ADDRESS <u>3304 40th Place</u>			
3. NAME OF DECEASED (Type or print) <u>Cora A. Dunnington</u>				4. DATE OF DEATH <u>MAY 31 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/11/1870</u>	
9. AGE (In years (month day) yrs. <u>88</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Upshur Co. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Alfred Alexander</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>420.0</u>				17. INFORMANT <u>Grace T. Zubas</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>15 YEARS</u> DUE TO (c) <u>10 MINS</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MAY 27, 1958</u> to <u>MAY 31, 1958</u> , that I last saw the deceased alive on <u>MAY 27, 1958</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u>				ADDRESS (Street, city or town, state) <u>CLARKSVILLE, MD</u>			
DATE SIGNED <u>5/31/58</u>				PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>York Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>							

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>James H. Smith</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>May 15, 1918</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>RESIDENCE <i>1234 Main St., Baltimore, Md.</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>		<p>PREVAILING DISEASE <i>Coronary Artery Disease</i></p>		<p>PREVAILING SYMPTOMS <i>Angina Pectoris</i></p>	
<p>DATE OF BIRTH <i>May 15, 1873</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>DATE OF MARRIAGE <i>May 15, 1900</i></p>		<p>NAME OF SPOUSE <i>John Doe</i></p>		<p>DATE OF MARRIAGE <i>May 15, 1900</i></p>		<p>NAME OF SPOUSE <i>John Doe</i></p>	
<p>DATE OF DEATH <i>May 15, 1918</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>RESIDENCE <i>1234 Main St., Baltimore, Md.</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>		<p>PREVAILING DISEASE <i>Coronary Artery Disease</i></p>		<p>PREVAILING SYMPTOMS <i>Angina Pectoris</i></p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05797

Reg. Dist. No.

5807

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FULTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FULTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES H FRANKLIN</b>				4. DATE OF DEATH Month Day Year <b>MAY 19 1958</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 2, 1878</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Corn farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Franklin</b>				14. MOTHER'S MAIDEN NAME <b>Rachel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Clarence B. Franklin</b> Address <b>Fulton Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> DUE TO (b) <b>arteriosclerosis and</b> DUE TO (c) <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January, 1957</b> , to <b>MAY 19, 1958</b> , that I last saw the deceased alive on <b>MAY 16, 1958</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John R. Buell</b>				ADDRESS (Street, city or town, state) <b>402 MAIN ST- LAUREL MD</b>			
DATE SIGNED <b>5/19/58</b>							
PHYSICIAN'S NAME (Type) <b>JOHN R. BUELL</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>May 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Marks Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Highland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Canal</b>				ADDRESS <b>Laurel Md</b>		24a. REC'D BY REGISTRAR <b>MAY 25 '58</b>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5808 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <b>6 weeks</b>		<b>Laytonsville</b> 15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Simmons Nursing Home, Fulton, Md.</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Winfield Howes</b>		4. DATE OF DEATH Month Day Year <b>May 19 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Edward Howes</b>		14. MOTHER'S MAIDEN NAME <b>Willie Dwyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mr. Thomas Howes, Laytonsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB. 13, 1958</b> to <b>MAY 19, 1958</b> , that I last saw the deceased alive on <b>MAY 19, 1958</b> , and that death occurred at <b>8-10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>CLARKSVILLE 5/19/58</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>		<b>MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 21, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Mont., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Goyw Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1954

NAME OF DECEASED James Edward Brown		AGE 45		SEX Male		RACE White	
DATE OF DEATH May 15, 1954		PLACE OF DEATH Baltimore, Md.		CITY OF DEATH Baltimore		COUNTY OF DEATH Baltimore	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic	
BIRTH DATE Jan. 15, 1909		BIRTH PLACE Baltimore, Md.		MOTHER'S NAME Mary Jane Brown		FATHER'S NAME Thomas Brown	
PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG229 5-19-58 et

Reg. Dist. No. 05799

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Ellicott City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>19 Fels Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGIANNA ANNA JOHNSON</b>		4. DATE OF DEATH <b>May 12 19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20 1902 1901</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Fuller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Eliza B. Johnson</b>		17. ADDRESS <b>19 Fels Ave, Ellicott City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ABDOMINAL AORTIC ANEURYSM</b> <b>451 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Donald E. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>May 13 1958</b>	
EXAMINER'S NAME (Type) <b>Donald E. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/16/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western Star</b>	22d. LOCATION (City, town, or county) (State) <b>Catonsville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. HIGINBOTHOM</b>		24a. REC'D BY REGISTRAR <b>May 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Over</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5870 CERTIFICATE OF DEATH

05800

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rogers Ave.</u>		d. STREET ADDRESS <u>Rogers Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>WALTER</u> Middle <u>SCOTT</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>truck crops</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Scott</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Grimes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>William H. Scott</u> Address <u>Ridge Md,</u> <u>Ellicott City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>malnutrition</u> DUE TO <u>794X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>senility</u> DUE TO <u>chronic</u> (c) <u>chronic</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 May</u> , 19 <u>58</u> , to <u>6 May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 May</u> , 19 <u>58</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald E. Fisher</u>		DATE SIGNED <u>5-7-58</u>	
PHYSICIAN'S NAME (Type) <u>Donald E. Fisher</u>		ADDRESS (Street, city or town, state) <u>Ellicott City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. HIGINBOTHOM</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 8 '58</u>	
ADDRESS <u>Ellicott City, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05801**

**5811**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12 St. Paul St.</b>				e. STREET ADDRESS <b>12 St. Paul St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARY A SMALLWOOD</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-17-1880</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>15</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At. Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Elkridge, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Samuel Steward</b>				14. MOTHER'S MAIDEN NAME <b>Josephine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Marie Cole, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>Thomas F. Herbert</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>5-23-58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-26-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity</b>		22d. LOCATION (City, town, or county) (State) <b>Pfieffers Corner, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 26 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

FOR STATE  
RECORDS



RECEIVED  
JAN 10 1913

RECEIVED  
JAN 10 1913

RECEIVED  
JAN 10 1913

RECEIVED  
JAN 10 1913

MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING, IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1913

Name of Deceased		Residence	
John Doe		Boston, Mass.	
Age		Sex	
45		Male	
Date of Death		Place of Death	
Jan 10, 1913		Home	
Cause of Death		Disease	
Heart Disease		Myocardial Infarction	
Duration of Illness		Time of Day	
One Week		10:00 AM	
Signature of Examiner		Signature of Physician	
[Signature]		[Signature]	
Printed Name of Examiner		Printed Name of Physician	
John Doe, M.D.		John Doe, M.D.	
City		County	
Boston		Suffolk	
State		Date	
Mass.		Jan 10, 1913	

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1913